

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-019044**

STATE FILE NUMBER

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **359**

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. **38**

**FILED MAY 23 1963**

1. PLACE OF DEATH  
a. COUNTY **Boone County**

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN **Columbia**

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION **Boone County Hosp.**

Inside Limits  
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE **Missouri** b. COUNTY **Cooper**

c. CITY OR TOWN **Woolbridge, Mo.**

Inside Limits  
Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)

Reside on Farm  
Yes ☒ No ☐

3. NAME OF DECEASED  
(Type or print)

First Middle Last

**Albert**

**Bruce**

4. DATE OF DEATH  
Month Day Year  
**5 21 1963**

5. SEX

**Male**

6. COLOR OR RACE

**Cauc.**

7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

**Mar 11, 1882**

9. AGE (last birthday)

**81**

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Farmer**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)  
**Cooper County, Mo.**

12. CITIZEN OF WHAT COUNTRY

**United States**

13a. FATHER'S NAME

**J. K. Bruce**

13b. MOTHER'S MAIDEN NAME

**Maggie Driscoll**

14. NAME OF HUSBAND OR WIFE (Maiden)

**Maggie McClahan**

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)  
**No**

16. SOCIAL SECURITY NO.

17. INFORMANT

**Earl Bruce (son)**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cerebral Thrombosis, massive**

INTERVAL BETWEEN ONSET AND DEATH

**3 days**

DUE TO (b)

**Arteriosclerosis**

**unk**

DUE TO (c)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **1962** to **5/21/63** and last saw her alive on **5/21/63**  
Death occurred at **3:00 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

**Richard MD**

22b. ADDRESS

**Prof Bldg. Columbia Mo**

22c. DATE SIGNED

**5/21/63**

23a. BURIAL, CREMATION, REMOVAL (Specify)

**Buried**

23b. DATE

**May 23 1963**

23c. NAME OF CEMETERY OR CREMATORY

**Kopp Chapel**

23d. LOCATION (City, town, or county)

**Cooper County Mo**

24. FUNERAL DIRECTOR

**Bill Thacher**

ADDRESS

**Boonville**

25. DATE RECD. BY LOCAL REG.

**May 21 1963**

26. REGISTRAR'S SIGNATURE

**Mrs RE Palmer**

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF:

DATE AMENDED

VS 300  
Rev. 4/59

**1 0109**

**2 0270**

**3**

**4 0**

**5 2**

**6**

**7 0**

**8 2**

**9 332X**

**10**

**11**

**12 1-0**

**13 3-0**

177839-2412

1010  
10722

0  
4  
0  
8

**STATEMENT BY LICENSED EMBALMER**

0-1  
0-2

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Ernest M. Shacker

Licensed Embalmer No. 3944

P. O. Address Boonville, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.